Extremity Imaging

Global and Physician Professional Payment

CPT® Code[1]	Description	Site of Service Component	RVU[2]	2020 National Average Medicare Rate[3]
Fluoroscopy				
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (e.g., cardiac fluoroscopy)	Office/Freestanding (Global)	1.18	$42.59
		Facility (Professional)	0.44	$15.88
		Facility (Technical)	0.74	$26.71
Fluoroscopic Guidance				
77002	Fluoroscopic guidance for all types of needle placement (eg, biopsy, aspiration, injection, or localization device)	Office/Freestanding (Global)	3.05	$110.07
		Facility (Professional)	0.79	$28.51
		Facility (Technical)	2.26	$81.56
Radiologic Examination				
73030	Radiologic examination, shoulder, minimum of 2 views	Office/Freestanding (Global)	0.93	$33.56
		Facility (Professional)	0.27	$9.74
		Facility (Technical)	0.66	$23.82
73100	Radiologic examination, wrist; 2 views	Office/Freestanding (Global)	0.92	$33.20
		Facility (Professional)	0.24	$8.66
		Facility (Technical)	0.68	$24.54
73110	Radiologic examination, wrist, complete, minimum of 3 views	Office/Freestanding (Global)	1.09	$39.34
		Facility (Professional)	0.25	$9.02
		Facility (Technical)	0.84	$30.32
73120	Radiologic examination, hand, 2 views	Office/Freestanding (Global)	0.85	$30.68
		Facility (Professional)	0.24	$8.66
		Facility (Technical)	0.61	$22.01
73130	Radiologic examination, hand, minimum of 3 views	Office/Freestanding (Global)	0.98	$35.37
		Facility (Professional)	0.25	$9.02
		Facility (Technical)	0.73	$26.35

Additional Information:

1. Fluoroscopy reported as CPT Codes 76000 is integral to many procedures including, but not limited, to most spinal, endoscopic, and injection procedures and should not be reported separately. For some of these procedures, there are separate fluoroscopic guidance codes which may be reported separately.

2. Fluoroscopic guidance reported as CPT 77002 is considered "bundled" with certain arthrography supervision and interpretation services (i.e., CPT Codes 73085, 73115, 73580 and 73615). NCCI Procedure-to-Procedure (PTP) edits can be found on the CMS website: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

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2. The 2020 physician relative value units (RVUs) are from the2020 Physician Fee Schedule (PFS) Final Rule, Addendum B accessible available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2020-PFS-FR-Addenda.zip.
3. The national average 2020 Medicare rates to physicians shown are based on the 2020 conversion factor of $36.0896 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2020 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Any payment rates listed may be subject to change without notice. Actual payment to a physician will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

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CPT® Code[1]	Description	Site of Service Component	RVU[2]	2020 National Average Medicare Rate[3]
Radiologic Examination				
73140	Radiologic examination, finger or fingers, minimum of 2 views	Office/Freestanding (Global)	1.00	$36.09
		Facility (Professional)	0.20	$7.22
		Facility (Technical)	0.80	$28.87
73560	Radiologic examination, knee, 1 or 2 views	Office/Freestanding (Global)	0.94	$33.92
		Facility (Professional)	0.24	$8.66
		Facility (Technical)	0.70	$25.26
73600	Radiologic examination, ankle, 2 views	Office/Freestanding (Global)	0.89	$32.12
		Facility (Professional)	0.24	$8.66
		Facility (Technical)	0.65	$23.46
73610	Radiologic examination, ankle, complete, minimum of 3 views	Office/Freestanding (Global)	0.98	$35.37
		Facility (Professional)	0.25	$9.02
		Facility (Technical)	0.73	$26.35
Bone / Joint Studies				
77071	Manual application of stress performed by physician or other health care professional for joint radiography, including contralateral joint if indicated	Office/Freestanding (Global)	1.50	$54.13
		Facility (Professional)	1.50	$54.13
		Facility (Technical)	NA	NA
77077	Joint survey, single view, 2 or more joints (specify)	Office/Freestanding (Global)	1.29	$46.56
		Facility (Professional)	0.49	$17.68
		Facility (Technical)	0.80	$28.87

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3. The national average 2020 Medicare rates to physicians shown are based on the 2020 conversion factor of $36.0896 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2020 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Any payment rates listed may be subject to change without notice. Actual payment to a physician will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

Extremity Imaging

Facility Payment

CPT® Code[1]	Description	Site of Service Component	APC[2]	Status Indicator (SI)[2]	2020 National Average Medicare Rate[2]
Fluoroscopy					
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (e.g., cardiac fluoroscopy)	Hospital	5523	S	$233.01
		ASC	NA	Z3	$26.35
Fluoroscopic Guidance					
77002	Fluoroscopic guidance for all types of needle placement (e.g., biopsy, aspiration, injection, or localization device)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
Radiologic Examination					
73030	Radiologic examination, shoulder, minimum of 2 views	Hospital	5521	Q1	$79.80
		ASC	NA	N1	Packaged
73100	Radiologic examination, wrist; 2 views	Hospital	5521	Q1	$79.80
		ASC	NA	N1	Packaged
73110	Radiologic examination, wrist, complete, minimum of 3 views	Hospital	5521	Q1	$79.80
		ASC	NA	N1	Packaged
73120	Radiologic examination, hand, 2 views	Hospital	5522	Q1	$112.07
		ASC	NA	N1	Packaged
73130	Radiologic examination, hand, minimum of 3 views	Hospital	5521	Q1	$79.80
		ASC	NA	N1	Packaged
73140	Radiologic examination, finger or fingers, minimum of 2 views	Hospital	5521	Q1	$79.80
		ASC	NA	N1	Packaged

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2. The national average 2020 Medicare rates for the hospital outpatient setting are from the 2020 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addendum B, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. The national average 2020 Medicare rates for the ambulatory surgical center setting are from the 2020 Ambulatory Surgical Center Payment Final Rule, Addenda AA and BB, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a hospital or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

Extremity Imaging

Facility Payment

CPT® Code[1]	Description	Site of Service Component	APC[2]	Status Indicator (SI)[2]	2020 National Average Medicare Rate[2]
Radiologic Examination					
73560	Radiologic examination, knee, 1 or 2 views	Hospital	5521	Q1	$79.80
		ASC	NA	N1	Packaged
73600	Radiologic examination, ankle, 2 views	Hospital	5521	Q1	$79.80
		ASC	NA	N1	Packaged
73610	Radiologic examination, ankle, complete, minimum of 3 views	Hospital	5521	Q1	$79.80
		ASC	NA	N1	Packaged
Bone / Joint Studies					
77071	Manual application of stress performed by physician or other health care professional for joint radiography, including contralateral joint if indicated	Hospital	5521	Q1	$79.80
		ASC	NA	N1	Packaged
77077	Joint survey, single view, 2 or more joints (specify)	Hospital	5522	Q1	$112.07
		ASC	NA	N1	Packaged

Status Indicator Information[2]

Status Indicator (SI)	Explanation
Q1	Payment is packaged if billed on the same claim as a HCPCS code assigned status indicator “S”, “T”, or “V”; otherwise payment is made through a separate APC payment
S	Significant procedure not subject to multiple procedure discount
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
Payment Indicator (PI)	**Explanation**
N1	Service is packaged into payment for other services; no separate ASC payment
Z3	Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS non-facility Practice Expense RVUsDE

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2. The national average 2020 Medicare rates and status indicators for the hospital outpatient setting are from the 2020 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addenda B and D1, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. The national average 2020 Medicare rates and status indicators for the ambulatory surgical center setting are from the 2020 Ambulatory Surgical Center Payment Final Rule, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a hospital or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

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hologic.com | Hologic@thepinnaclehealthgroup.com | 1.866.369.9290